



KEWEENAW BAY INDIAN COMMUNITY

COMMUNITY ASSISTANCE PROGRAMS (C.A.P.)

16429 Beartown Road, Baraga, MI 49908

Telephone: (906) 353-8137 or (906) 353-6623 x4162

Fax: (906) 353-4141

FY2015 CAP HOUSEHOLD APPLICATION

You are required to update physical address with Enrollment before applying for **ANY** of the programs in the CAP office

HEAD OF HOUSEHOLD INFORMATION

LAST Name	FIRST Name	Middle	Social Security #	DOB	AGE	TRIBAL ID

OTHER HOUSEHOLD MEMBERS INFORMATION

LAST Name	FIRST Name	Relation to HOH	Social Security # Grant programs only	DOB	AGE	TRIBAL ID

Mailing Address	Physical Address	City/State/Zip	County	Telephone/cell/message

Is anyone in the home a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does he/she have a DD214? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	
Does he/she receive benefits from the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate what benefits he/she is receiving:	Would he/she like more information on programs available through the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE CHECK EACH OF THE FOLLOWING for COMPLETED APPLICATION:

- ☐ I certify that all of the information in this application is true, accurate, and complete to the best of my knowledge. I understand that giving false or incomplete information may result in a referral to the prosecutor for fraud, and/or recovery of any funds paid out on behalf of me, my household, or a minor in my care.
- ☐ I understand that failure to submit a completed application and all of its required documents will be considered incomplete and a determination of funding benefits will not be made on the request until all documents are received and application is filled in completely.
- ☐ A decision will be made on my application within 10 working days of my initial application request date.
- ☐ I understand that I have a right to file an appeal for denials and decisions not made in a timely manner. Hearings-Appeals procedure sheets can be obtained in the CAP office.
- ☐ I hereby authorize the Release of Information on myself or any other member in my household, in order to obtain information specific to this application and related requests.

Please provide current Tribal Ids for ALL member(s) in the household.

Head of Household/Applicant Signature

Date



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COMMUNITY NEEDS ASSISTANCE PROGRAM

Lifeline Application FY2015

Baraga County and Marquette Trust Property Residences

DATE	HEAD OF HOUSEHOLD	REQUESTOR'S NAME
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Are you eligible for medical travel advancement or reimbursement from any of the following resources?

Check that all apply.

MEDICAID ☐ UPHP ☐ HEALTHY START ☐ INSURANCE ☐ VETERANS ASSOCIATION ☐ MEDICAL TRANSPORT SERVICES ☐ OTHER ☐

Documentation needed for completed application – Medical Travel.

Completed CAP Application	Primary Physician
Ensure all information specified is answered. KBIC Tribal ID(s) updated with Enrollment.	Documentation statement from primary physician stating the need for lifeline services.

Statement for request.

SIGNATURE	DATE

OFFICE USE ONLY

☐ APPROVED

Recipient: _____

Amount: \$_____

☐ DENIED

Reason: _____

You have a right to file an appeal for denials and decisions not made in a timely manner.

Hearing process sheets can be obtained in the CAP office.

Sue Ellen Elmsblad, CAP Administrator or

Date

Kim Klopstein, CAP Administrator Assistant